BROWN (F. T.)

Case of Urethro Fistula

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CASE OF URETHRO-RECTAL FISTULA.

By F. Tilden Brown, M.D.

E. J. F., male, twenty-seven, U. S. Admitted to the Presbyterian Hospital August 15, 1894. Discharged, cured, September 30th. Family history negative.

Personal Previous History.—Several attacks of gonorrhœa. The last was three years before the occurrence of a prostatic abscess, which the patient attributed to severe compression of the penis and urethra during an emission. Prostatotomy was followed by a small urinary fistula. Extravasation of urine and pus followed and required additional incisions. A week later the right seminal vesicle was removed as a dangerous septic focus. These operations as well as five subsequent ones were performed in San Francisco.

Five months later, August 2, 1892, he had the first operation for the cure of his fistula. Severe bleeding and abscess formation defeated the effort.

On March 15, 1893, he had the second operation which was apparently ruined the same night by faulty catheterization.

The third operation was made more promising by having had established supra-pubic drainage, but during the third week, while still in bed, the old fistula opened.

On June 1, 1893, a fourth operation was done employing supra-pubic drainage and extensive perineal flaps. Four days later the sutures parted. He had now a more extensive fistula than ever before. On October 15, 1893, a fifth operation was performed on the same principles as the last, *i.e.*, a plastic augmented by supra-pubic drainage; there was but a most temporary occlusion of the fistula. Two months later he left the hospital, the supra-pubic wound closed and all urine issuing through the anus. He came east in July,

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1894, and entered the Presbyterian Hospital August 15th. He was apparently and confessedly addicted to morphine. Three weeks were devoted to correcting this excess, and to a study of the conditions presented by the fistula, bladder, urethra, and urine. The rectal aperture of the fistula was just within the internal sphincter. It admitted the tip of the index finger into the prostatic urethra. The tonicity of the sphincter vesicæ internus was sufficient to often retain two or three ounces of urine. When this began to escape into the prostatic urethra he would voluntarily empty his bladder into the rectum, whence it issued at once through the anus, the muscles and tissues of which had been impaired by previous lesions incidental to disease and former operations. Two moderate strictures of the urethra existed; these were divided, and the canal healed at a uniform calibre of 32 French. Ten days later an operation for the cure of the fistula was performed. A perineal incision leading into the membranous urethra was made. Through this the right forefinger was passed to the prostatic urethra while the left forefinger in the rectum came in contact with it anddisclosed very thin tissues surrounding the fistulous track, so attenuated as to offer little hope of successful holding of sutures.

With the author's short wire rectal speculum distending the anus and rectum, and one finger in the prostatic urethra, the thin margin of the opening was trimmed with curved scissors, then with four sutures of silkworm-gut passed from the rectal side, but under guidance of sight, and the finger in the urethra, the opening was closed. Now a flap of rectal mucous membrane an inch in width and an inch and three-quarters in length was dissected up and brought down over the silkworm sutures where it was secured with silk, to form at least a temporary shield. A rubber perineal catheter was passed to the bladder and retained by the author's tube holder. Defæcation was prevented for nine days. The patient was confined to bed for two weeks. The perineal tube was worn for three weeks. At no time after the operation was there any escape of urine through the fistula. The patient made a complete recovery and returned to California two months later, passing all his urine voluntarily by the urethra from the meatus.